JUVENILE OFFENDERS

Background

The responsibility for children's mental health is dispersed across multiple systems: schools, primary care, the juvenile justice system, child welfare, and substance abuse treatment (U.S. Department of Health and Human Services, 1999). Unfortunately, an increasing number of youth with mental health disorders continue to enter and remain involved in the juvenile justice system.

The National Center for Mental Health and Juvenile Justice and the Council of Juvenile Correctional Administrators conducted a study of mental health prevalence among youth involved in the juvenile justice system. According to this study, 70% of youth meet the criteria for at least one mental health disorder (National Center for Mental Health and Juvenile Justice, 2006).

Estimates provided by both state and local juvenile justice facilities throughout the U.S. suggest that juvenile offenders have significant mental health treatment needs. A study conducted by the Virginia Department of Juvenile Justice (DJJ) showed that more than 40% of males and almost 60% of females in detention homes were in need of mental health services; more than seven percent of males and more than 15% of females had urgent mental health treatment needs (Joint Commission for Behavioral Health Care, Virginia State Crime Commission and Virginia Commission on Youth, 2002).

Data compiled from multiple national studies reveal that the rate of mental health disorders is higher among youth in the juvenile justice population than in the general population, as illustrated in Table 1. The most common psychiatric disorders seen in juvenile offenders are listed in Table 2.

Juveniles entering the justice arena typically manifest complex mental health and behavioral health needs. According to a national report released by the National Alliance for the Mentally Ill (NAMI), 36% of respondents to a nationwide survey of families having children with severe mental illnesses said that their children were in the juvenile justice system because of the unavailability of mental health care services (NAMI, 1999).

Table 1

Prevalence of Mental Disorders in the Juvenile Population and General Populations

Disorders	General Population (%)	Juvenile Justice Population (%)
Mood Disorders	5-9	10-88
Attention Deficit Hyperactivity Disorder	3-7	2-76
Learning Disorder	4-9	36-53
Mental Retardation	1	13
Posttraumatic Stress Disorder	6	5-49
Conduct Disorder	1-10	32-100
Psychotic Disorders	.05-5	1-16
Substance Abuse/Dependence	5.5-9	46-88

Source: American Psychiatric Association, as cited by Boesky, 2002.

Table 2

Most Common Psychiatric Disorders Seen Among Juvenile Offenders

Conduct Disorder	Attention Deficit Hyperactivity Disorder
Oppositional Defiant Disorder	Posttraumatic Stress Disorder
Major Depression	Mental Retardation
Dysthymic Disorder	Learning Disorders
Bipolar Disorder	Fetal Alcohol Syndrome

Source: Boesky, (2002).

Comorbid Disorders

As reported by the National Mental Health Association (NMHA), co-occurring disorders are a significant problem for youth in the nation's justice system (2004). One study found that 79% of youth in the juvenile justice system who met criteria for one mental health disorder also met criteria for two or more diagnoses. In addition, 60% met criteria for a substance use disorder (National Center for Mental Health and Juvenile Justice, 2006). Co-occurring mental health and substance abuse problems place distinct demands upon treatment programs. Solutions for treating co-occurring disorders for youth in the justice system are complicated, particularly because adolescents often return to the peer, family, and community environments that supported and promoted their substance use.

Findings from Studies

The findings of a study by the Research & Training Center on Family Support and Children's Mental Health (2001) compare mental health needs and demographics among a sample of youth.

These are based on data gathered on youth who were involved in the system but not confined, youth incarcerated for their crimes, as well as youth adjudicated to residential treatment. The study results indicate that children at risk for institutional placement are placed according to the primary type of dysfunction they evidence, with behaviorally-disordered children becoming incarcerated and emotionally-disordered children placed into the state mental health system. Other factors related to subsequent institutional placement included chronic school truancy, prior outpatient substance abuse or mental health treatment, and prior use of a firearm.

Youth within the juvenile justice system are at high risk for psychiatric conditions that may have contributed to the risk of offending or which may interfere with rehabilitation (Columbia University, 2002). Studies also reinforce a high need for mental health services and a lack of systematic assessment (Research & Training Center on Family Support and Children's Mental Health, 2001). Juvenile courts can have a positive mental health orientation and provide a foundation to build a stronger system of care collaboration and the establishment evidence-based practices in the juvenile justice system (Columbia University).

Evidence-Based Approaches

There are promising approaches in providing mental health services in the juvenile justice system. Heightened awareness of mental health disorders has led to increased research and new treatment practices. Among delinquent juveniles who receive structured, meaningful and sensitive treatment, recidivism rates are 25% lower than those in untreated, control groups. Highly successful programs reduce rates of re-offense by as much as 80% (Coalition for Juvenile Justice, 2000).

The National Center for Mental Health and Juvenile Justice (NCMHJJ) (2002) has compiled information on best practices for treatment of juvenile offenders. These interventions incorporate several treatment components and are discussed in the following paragraphs. Although several of these treatment approaches may be applied and utilized in the institutional setting, the following discussion refers to the application of these approaches in the community setting.

Wraparound

The wraparound approach focuses on treating children with serious emotional problems and developing individualized, child-centered, family-focused, community-based, and culturally competent services (NCMHJJ, 2002). The design is enhanced to promote programs that provide integrated service systems for youth with serious emotional problems operating across the mental health, juvenile justice, child welfare and education systems (Kamradt, as cited by the NCMHJJ). Wraparound improves public safety while keeping youth in their family systems, close to home and community (Research & Training Center on Family Support and Children's Mental Health, 2001).

Research shows that, while implementing wraparound can be challenging, it is a promising practice in treating youth involved with the juvenile justice system. An example of a successful program is Wraparound Milwaukee in Milwaukee County, Wisconsin (NMHA, 2004). Preliminary evaluation data indicates that children served by this program have shown significant improvements.

Integrated Systems of Care

Integrated systems of care typically involve collaboration across a number of agencies such as juvenile justice and mental health, with the goal of developing coordinated plans for family-centered services, and building upon youth and family strengths.

Multisystemic Therapy

Multisystemic Therapy (MST) provides an integrative, cost effective, family-based treatment with focus on improving psychosocial functioning for youth and families so that the need for out-of-home placements is reduced or eliminated. MST addresses the numerous factors of serious antisocial behavior in juvenile delinquency. MST interventions focus on the individual child and their family, peers, school and neighborhood/community support (Henggeler, as cited by the NCMHJJ, 2002).

The underlying premise of MST is that the behavioral problems of children and adolescents are maintained through problematic interactions within or between two or more of these systems. MST has an extensive body of research supporting its effectiveness with juvenile populations with emotional and behavioral problems. Evaluations have shown reductions up to 70% in long-term rates of re-arrest and reductions up to 64% in out-of-home placements, along with improvements in family functioning and decreased mental health problems (NMHA, 2004).

Functional Family Therapy

Functional Family Therapy (FFT) is a family-based prevention and intervention program that combines and integrates established clinical therapy, empirically supported principles, and extensive clinical experience. This model allows for intervention in complex problems through clinical practice that is flexibly structured, culturally sensitive and accountable to families (Sexton and Alexander, as cited by the NCMHJJ, 2002).

FFT focuses on the delinquency problem and seeks to reduce it by identifying obtainable changes (NMHA, 2004). A research study indicates that, after a year, youth who participated in FFT had a re-arrest rate of approximately 25% versus 45 to 70% for youth who did not (NMHA).

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is based on the idea that thoughts, beliefs and attitudes determine emotion and behavior. It is an excessively instructive approach that involves teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that will lead to more adaptive behavior in challenging situations. This approach is especially beneficial for youth in the juvenile justice system because it is very structured and focuses on the triggers for disruptive or aggressive behavior (NMHA, as cited by the NCMHJJ, 2002). CBT addresses poor interpersonal and problem-solving skills in teaching participants social skills, coping, anger management, self-control, or social responsibility (NMHA, 2004).

Multidimensional Treatment Foster Care

Multidimensional Treatment Foster Care recruits, trains and supervises foster families to provide youth with close supervision, fair and consistent limits and consequences and a supportive relationship with an adult (NCMHJJ, 2002). As an alternative to corrections, it places juvenile offenders who require residential treatment with these carefully trained foster families. It promotes both rehabilitation and public safety (Chamberlain, 1998). During the placement timeframe, the youth's biological or adoptive family is also receiving family therapy to further the goal of returning the youth to that family (NMHA, 2004).

Components of Effective Treatment for Youth in the Juvenile Justice System

According to the Coalition for Juvenile Justice (2000), there are nine components of effective treatment for juvenile offenders:

- Highly structured, intensive programs focusing on changing specific behaviors;
- Development of basic social skills;
- Individual counseling that directly addresses behavior, attitudes, and perceptions;
- Sensitivity to a youth's race, culture, gender, and sexual orientation;
- Family member involvement in the treatment and rehabilitation of children;
- Community-based, rather than institution-based treatment;
- Services, support and supervision that "wrap around" a child and family in an individualized way;
- Recognition that youth think and feel differently than adults, especially under stress; and
- Strong aftercare treatment.

Incarcerated Juveniles

The juvenile justice system has long been used as a secure setting for juveniles with a variety of mental health issues and disorders. Youth with severe emotional disorders often continually get in trouble and end up being incarcerated for their own or society's protection. The juvenile justice system is the "last stop" for juveniles with mental health disorder, especially when they are seen as untreatable or when appropriate mental health services have not been available or accessed (Boesky, 2002). The institutional setting offers effective mental health interventions based on the treatment needs for the child. It is important to note that many juvenile justice facilities have managed their youth with mental health disorders so well that they need not rely upon community-based mental health agencies (Boesky).

In 2003, the U.S. House of Representatives Committee on Government Reform Special Investigations Division conducted a survey of every juvenile detention facility in the United States. This survey was to ascertain what occurs when community mental health services are not readily available. The survey revealed that two-thirds of the juvenile detention facilities responding to the survey have in their custody youth waiting for community mental health services (U.S. House of Representatives Committee on Government Reform Special Investigations Division, 2004).

The National Center for Mental Heath and Juvenile Justice (NCMHJJ) reported that female offenders in the juvenile justice system are at a higher risk for mental health disorders than males (Wasserman, et. al., 2005, as cited by NCMHJJ, 2006). However, they do experience comparable rates of disruptive disorder and substance use disorders (NCMHJJ). Furthermore, youth in the juvenile justice system are also believed to have experienced varying rates of trauma such as post traumatic stress disorder (PTSD) (NCMHJJ). Traumatic events include physical abuse, sexual abuse, domestic violence, community violence, and/or other disturbing acts (NCMHJJ).

Virginia's Mental Health/Juvenile Detention Center Projects

The information contained in this section is taken from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services' *Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and their Families* (2007).

Virginia's local juvenile detention facilities were not equipped or funded to provide adequate behavioral health care services to juvenile offenders. In response to this, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Department of Juvenile Justice (DJJ) funded five projects with a combination of federal and state funding to allow Community Service Boards (CSBs) to provide mental health screening, assessment services, and community-based referrals for youths in local juvenile detention facilities. The 2006 General Assembly appropriated $1.14 million for nine additional projects and also covered the federal share of funding for the others, to bring the total number of projects to 14. The 2007 General Assembly provided $900,000 additional funding. The programs serve approximately 2,500 youth annually. Programs in operation include:

- Alexandria CSB/Northern VA Detention Home
- Blue Ridge Behavioral Health/Roanoke Detention Center
- Colonial CSB/Merrimac Detention Center
- Danville CSB/W.W. Moore Detention Center
- New River Valley CSB/New River Valley Detention Center
- Region 10 CSB/Blue Ridge Detention Center
- Chesapeake CSB/Chesapeake Juvenile Justice Center
- Chesterfield CSB/Chesterfield Juvenile Detention Home
- Crossroads CSB/Piedmont Juvenile Detention Home
- Norfolk CSB/Norfolk Juvenile Detention Home
- Planning District One Behavioral Health/Highlands Juvenile Detention Home
- Richmond Behavioral Health/Richmond Juvenile Detention Home
- Valley CSB/Shenandoah Juvenile Justice Center

Programs that commenced in Fiscal Year 2007 are:

- Henrico CSB/James River Juvenile Detention Home
- Fairfax CSB/Fairfax County Juvenile Detention Center
- Loudoun CSB/Loudoun Juvenile Detention Home
- Northwestern CSB/Northwestern Juvenile Detention Home
- Prince William CSB/Prince William Juvenile Detention Home
- Virginia Beach CSB/Virginia Beach Juvenile Detention Center
- District 19 CSB/Crater Juvenile Detention Center
- Rappahannock CSB/Rappahannock Juvenile Detention Center

These projects have been successful in providing the following mental health services to juvenile offenders:

- 2,531 mental health screenings were completed;
- 1,091 youth received case management services from mental health case managers;
- 1,299 youth received individual counseling with mental health clinicians;
- 1,113 youth received group counseling with mental health clinicians;
- 238 youth received crisis intervention services with mental health clinicians;
- 99 youth were prescribed medications; and
- 568 service plans were developed and follow-up at the respective CSB.

Conclusion

Community agencies, such as social services, public school divisions, and juvenile justice, frequently serve youth with untreated or under-treated mental health problems. The juvenile justice system serves those youth whose behavior or actions bring them under the purview of the court.

The juvenile justice system can neither select its service population nor refuse to accept a child based on his mental health diagnosis (Boesky, 2002). Although juvenile offenders with mental health disorders are a challenging population, promising intervention strategies do exist. However, it is important to remember that, although the juvenile justice system should respond to the mental health needs of children in its care, the juvenile justice system cannot supplant the mental health system (Boesky).

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Additional Resources

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Organizations/Weblinks

Cognitive Behavioral Therapy

http://www.cognitivetherapy.com/index.html

Functional Family Therapy Online

Holly DeMaranville, FFT Communications Coordinator
206-369-5894
E-mail: hollyfft@comcast.net
http://www.fftinc.com/contact.php

Licensed Functional Family Therapy Programs in Virginia

York County Department of Community Services
Juvenile Services Division - Functional Family Therapy
224 Ballard Street - Yorktown, VA 23690-0532
757-564-2487
E-mail: stumpl@yorkcounty.gov

Loudoun County Department of Mental Health, Mental Retardation and Substance Abuse Services
Functional Family Therapy
102 Heritage Way, Suite 302 - Leesburg, VA 20176
703-771-5239

Licensed Multisystemic Therapy Programs in Virginia

Services provided by these projects

- Functional Family Therapy (Alexandria, Cumberland Mountain and Planning District One)
- Multi Systemic Therapy (Richmond)
- Alternative Day Support Services (Cumberland Mountain)
- Crisis Response Services (Planning District One)
- Psychiatric Services (Planning District One)

Central Virginia Community Services
2241 Langhorne Road - Lynchburg 24501
434-847-8050 or TTD 434-847-8062
http://www.cvcsb.org

Henrico Area Mental Health and Retardation Services
10299 Woodman Road - Glen Allen 23060
804-261-8585 or TTD 261-8484
http://www.co.henrico.va.us/mhmr

Richmond Behavioral Health Authority
107 South Fifth Street - Richmond, VA 23219
804-819-4000 or 804-819-4100 Crisis
http://www.rbha.org/mentalhealth.htm

Virginia Beach Community Services Board
297 Independence Boulevard Pembroke Six, Suite 208 - Virginia Beach, VA 23462
757-437-6100 or TTD 757-437-6157

Multidimensional Treatment Foster Care

http://www.mtfc.com

Multisystemic Therapy Services
710 J. Dodds Boulevard - Mt. Pleasant, SC 29464
843-856-8226
E-mail: marshall.swenson@mstservices.com